College of Nursing of New Brunswick | Ordre de la pratique infirmière du Nouveau-Brunswick

Standards of Practice: DOCUMENTATION

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Mandate

Public protection through regulation of nurses in New Brunswick.

Under the *Nurses Act,* the College of Nursing of New Brunswick (CNNB) is legally responsible for protecting the public by regulating registrants of the nursing profession in New Brunswick. Regulation makes the profession, as well as individual nurses, responsible for safe, competent, compassionate and ethical nursing practice.

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Words or phrases shown in **bold** on first appearance are found in the glossary.

The College of Nursing of New Brunswick standards of practice outline accountabilities of nurses, provide guidance in specific areas of practice, and inform the public, including clients and organizations, about what they can expect of nurses. They apply to all nurses, regardless of their role, job description or area of practice. Nurses are expected to practice in compliance with relevant legislation, the Code of Conduct, all standards of practice and applicable organizational requirements. Not complying with legislation or failing to meet the standards of practice may be considered professional misconduct. *Adapted with permission from the College of Nurses of Ontario.*

INTRODUCTION

Documentation by registered nurses (RNs) and nurse practitioners (NPs) is fundamental to recording and evaluating **nursing practice** and is only as complete as the information entered into permanent record. As self-regulated professionals, RNs/NPs[1] are accountable for ensuring that their documentation is complete, accurate and in compliance with the *Standards of Practice: Documentation*, the *Code of Conduct,* all applicable standards of practice, and organisational requirements.

These *Standards of Practice: Documentation* explain the regulatory and legislative requirements for nursing documentation. As technology continues to evolve, RNs/NPs are required to meet documentation requirements regardless of the format or platform used. To help RNs/NPs understand and apply the standards to their individual practice, the content is divided into three standard statements that describe broad practice principles. Each standard statement is followed by corresponding indicators that outline an RN's/NP's responsibility and accountability when documenting.

[1] CNNB is responsible for regulating registered nurses, graduate nurses, nurse practitioners and graduate nurse practitioners in New Brunswick, as such the abbreviation "RNs/NPs" is used in this document and refers to all aforementioned designations. Licensed practical nurses in New Brunswick are regulated by the Association of New Brunswick Licensed Practical Nurse.

PRINCIPLES OF DOCUMENTATION

The following principles apply to documentation by RNs/NPs:

- Documentation is a nursing action, that produces a written and/or electronic account, demonstrating the application of the **nursing process**.
- It demonstrates that the RN/NP has applied the nursing knowledge, skill and judgement required by relevant legislation, the *Code of Conduct*, *Standards of Practice: Documentation*, and organisational requirements.
- Documentation includes any pertinent information that is received by the RN/NP from those within the **health care team**.
- Documentation also reflects the **client**'s perspective and promotes intra/interprofessional **communication**.
- Clear, complete and accurate documentation is essential for safe nursing practice as it ensures critical information is effectively communicated to support informed decision making (CRNM, 2024).
- **Co-signing** implies shared accountability and indicates the person co-signing witnessed or participated in what was documented (NSCN, 2024).
- It is acceptable to document for another's care provision during an emergency, when outlined in employer policy with clear direction regarding how and when to do so (e.g. during resuscitation by a code team).
- Quality documentation is required in every area of nursing practice, including virtual and tele-health.
- Documentation occurs as close as possible to the time the services were provided to enhance the accuracy and the overall credibility of records (CRNNL, 2021).
- Organisations support documentation by having requirements specific to documentation, by supplying appropriate tools for documentation, and by prioritizing documentation as an aspect of nursing practice, allowing time for documentation.
- Self-employed RNs/NPs should have policies and/or processes in place related to documentation and the collection, storage, dissemination and disposal of client information.

PURPOSE OF DOCUMENTATION

Documentation by RNs/NPs has many purposes, including but not limited to the following (NSCN, 2024; CNPS, 2020):

- serves as a communication tool;
- promotes continuity of services provided, including the creation and modification of the **care plan**— inaccurate or incomplete documentation can lead to fragmented nursing practice, repetition of tasks and delays or omissions of therapies;
- demonstrates RNs'/NPs' accountability to the client, to the organisation and to the profession of nursing;
- informs quality improvement processes, including risk management;
- may be used in legal investigations and other legal proceedings;
- is a source of data in evidence-informed research; and
- is a source of information in making funding and resource management decisions.

STANDARD 1: COMMUNICATION

RNs/NPs document accurate, pertinent, and comprehensive information. They apply their knowledge, skills, and judgment to ensure that documentation is clear, complete, and precise.

INDICATORS

RNs/NPs shall:

1.1 document at the time services are provided or an event occurs (or as soon as possible) in a chronological order, including all aspects of the nursing process and do not document before the service is provided;

1.2 document both objective and subjective data in a clear and concise manner;

1.3 document informed consent for treatments or interventions performed;

1.4 document communication with family members/significant others and substitute decision-makers, that may impact the client's health outcome or the plan of care (noting the date, time and content of the communication);

1.5 document relevant communication with other health care team members including name and designated title, the date and time, the mode of communication (such as in-person, telephone, email, video or other digital platforms), and the outcome of the discussion;

1.6 review their documentation for accuracy and completeness, including when generated through the use of technology such as **artificial intelligence**;

1.7 ensure that relevant client information kept in temporary documents (e.g. shift reports, care plans and communication books), as well as any images, videos, or information exchanged through the use of technology is captured in the permanent record;

1.8 only use abbreviations and symbols when each has a distinct interpretation and is approved by the organisation;

1.9 document education provided, including both formal and informal;

1.10 document nursing practice when using virtual and telecommunication technologies (for example, providing telephone advice or when using a virtual platform to provide nursing services);

1.11 document any unanticipated, unexpected or abnormal incidents according to organisational requirements, recording the facts of the incident and any subsequent related services provided; and

1.12 document using respectful, non-discriminatory language that reflects **cultural safety** and respects the client's identity, context, and lived experience, and avoids stereotypes and assumptions.

STANDARD 2: ACCOUNTABILITY AND LIABILITY

RNs/NPs document in accordance with relevant legislation, the Code of Conduct, Standards of Practice: Documentation, and organisational requirements.

INDICATORS

RNs/NPs shall:

2.1 document more frequently when a client is at increased risk of harm, is unstable, or there is a higher degree of complexity involved in the services provided (CNPS, 2020; CRNM, 2024);

2.2 document the date and time that the service was provided;

2.3 provide a signature and professional designation (RN, GN, NP or GNP) with all documentation— the use of initials is acceptable when a master list of signatures/initials is incorporated into the documentation tool;

2.4 adhere to organisational requirements for electronic signature;

2.5 document legibly and in permanent ink when documenting on paper;

2.6 indicate when an entry is late, including the date and time of the service that was provided along with the date and time of the entry into the record;

2.7 not delete their own documentation— if corrections are needed, they ensure their original entry remains retrievable and visible;

2.8 never delete, alter or modify anyone else's documentation;

2.9 document when information for a specific time frame has been lost or cannot be recalled, indicating clearly when an entry is replacing lost information;

2.10 only co-sign when there is supporting employer policy (e.g. independent double check of medication preparation, agreement on calculated dosage);

2.11 identify any individual with whom client information is shared, including name and professional designation and what client information was provided; and

2.12 only use artificial intelligence to assist with documentation when:
a. The artificial intelligence tool is approved by the organisation; and
b. Organisation policies and processes are in place to support the use of artificial intelligence for documentation.

STANDARD 3: INFORMATION SECURITY

RNs/NPs safeguard client information by maintaining privacy and confidentiality which includes acting in accordance with information retention and destruction policies and procedures that are consistent with relevant legislation the Code of Conduct, the Standards of Practice: Documentation, and organisational requirements.

INDICATORS

RNs/NPs shall:

3.1 understand and adhere to relevant legislation, *the Code of Conduct, the Standards of Practice : Documentation, and organisational requirements* related to **confidentiality**, **privacy** and security of client information;

3.2 only access client information for purposes consistent with professional obligations;

3.3 facilitate the rights of the client or substitute decision-maker to access, inspect, and obtain a copy of the client record, as defined by *Personal Health Information Privacy and Access Act* and organisational requirements;

3.4 obtain informed consent from the client or substitute decision-maker to use and disclose information to others outside the health care team;

3.5 maintain the security of personal health records during the transmission or disclosure of information including when using technologies such as email or secure messaging;

3.6 retain records in accordance with legislation and or organisational requirements;

3.7 ensure the secure and confidential destruction of temporary documents and permanent records that have passed their retention period, according to organisational requirements; and

3.8 use only their assigned accounts to access and enter information into any electronic record, and take reasonable steps to maintain the security of their authentication credentials for information systems, such as username and password.

GLOSSARY

Artificial Intelligence (AI): AI broadly refers to computer programs performing tasks historically undertaken by human intelligence. AI is computer code that carries out rapid analysis and evaluation of data, similar to human intelligence processes, such as reasoning, decision-making, or learning from prior experiences. These processes result in outputs such as written information, robots performing tasks, pictures, predictions based on historical data, or other outputs.

Care plan: An individualized and comprehensive plan guiding the nursing care for a client. The purpose is to enhance communication between care providers so care is provided consistently and client goals are achieved

Client: Individuals, families, groups, populations or entire communities who require nursing expertise. The term "client" reflects the range of individuals and/or groups with whom nurses may be interacting. In some settings, other terms may be used such as patient or resident. In education, the client may also be a student; in administration, the client may also be an employee; and in research, the client is usually a subject or participant

Communication: The transmission of verbal and/or non-verbal messages between a sender and a receiver for the purpose of exchanging or disseminating meaningful, accurate, clear, concise, complete and timely information (includes the transmission using technology)

Confidentiality: The ethical obligation to keep someone's personal and private information secret or private

Co-signing: Refers to a second or confirming signature of a witnessed event indicating they have verified the accuracy and appropriateness

Cultural safety: Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care

Documentation: written or electronically generated information about a client that describes the care, including the observations, assessment, planning, intervention and evaluation or service provided to that client.

Health care team: Members of the intraprofesssional and/or interprofessional team and/or community supporting client care. This also includes the health and other government sectors, representatives from private, voluntary, and non-profit groups, as well as Indigenous and traditional healers.

Nursing practice: the application of specialized, evidence-based knowledge drawn from nursing theory and the health and human sciences, including the principles of primary health care. It encompasses roles in clinical practice, research, education, consultation, management, administration, policy development, and regulation.

Nursing process: A scientific method used by nurses to ensure the quality of client care. This approach can be broken down into four separate steps: assessment, planning, implementation and evaluation.

Privacy: (1) Physical privacy is the right or interest in controlling or limiting the access of others to oneself; (2) informational privacy is the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared. A person has a reasonable expectation of privacy in the health-care system so that health-care providers who need their information will share it only with those who require specific information

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